Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 43/2013

I, Evelyn Felicia Vicker, Acting State Coroner, having investigated the death of ***Palmerino Zappacosta****, with an Inquest held at the Perth Coroners Court, Court 51, 501 Hay Street, Perth, on 16 December 2013 find the identity of the deceased was* ***Palmerino Zappacosta*** *and that death occurred on or about the 16 February 2012 at Royal Perth Hospital as a result of Sepsis associated with a pericolic abscess, complicated by terminal large intestinal haemorrhage in the following circumstances -*

Counsel Appearing:

Sgt L Housiaux assisted the Acting State Coroner
Mr C Beetham (instructed by the State Solicitors Office) appeared on behalf of the Department of Corrective Services.

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INTRODUCTION

On 10 February 2012 Palmerino Zappacosta (the deceased) was admitted to Royal Perth Hospital (RPH) for a gastrointestinal (GI) bleed. His condition deteriorated and he died at about midnight between 15 & 16 February 2012.

At the time of his death he was a sentenced prisoner, usually resident at Casuarina Prison Infirmary, Casuarina, and his death consequently is required to be inquested pursuant to section 22(1)(a) *Coroners Act 1996*.

The deceased was 86 years of age.

BACKGROUND[1]

The deceased was born in Comune di Bucchaianico, Italy on 17 December 1925. He self reported a happy childhood and left school at the age of 13, at the beginning of the Second World War.

He migrated to Australia when he was 26 years of age and on 11 October 1952 he was granted Entry and Permanent Resident Status. He worked as a factory supervisor, and later worked as a supervisor for a firewood and timber company for 15 years, and was a truck driver for a bread company for 6 years.

[1] Exhibit 1 Volume 1 Tab 12 and Exhibit 1 Volume 2 Tab 1

When he spoke his English was broken, but his son recalls him having a very good knowledge of the language.

He married a Dutch woman and had five children, comprising three sons and two daughters. He was described by his family as having a self-centred, dominating personality and he was known to be violent towards his wife.

The deceased and his wife were estranged for some years prior to 2000 and the fact of his wife leaving him appears to have precipitated a decline in his mental health and depressive symptoms. He lived alone on his small farming property and had restricted contact with his family. Following the estrangement he became quite prone to abnormal behaviour which further distanced family members from him. They believed he was being manipulative.

Records confirm the deceased never obtained Australian Citizenship and in November 2002, while in prison, he was named a person of interest by the Department of Immigration and Citizenship (DIAC). In February 2007 DIAC advised him his Resident Visa had been cancelled.

Following the deceased's imprisonment one of his sons was the only child to remain in contact with him.

The deceased's son recalls[2] the deceased having health problems for almost as long as he could remember, particularly with his blood pressure. He had an extensive medical history and was on multiple medications.

The deceased had suffered a mild stroke in the early 1990s and as a result had a right leg amputation requiring a prosthesis. He was recorded as somewhat unsteady on his feet, and in conjunction with his difficulties with his family, suffered ongoing depressive symptoms.

The deceased was a psychiatric inpatient at RPH from 15 May to the 3 June 1998 and again at Bentley Hospital from 12 September to 22 September 1999. He was discharged to the care of the Mill Street Centre (MSC) and again underwent a short term of voluntary admission for a review of his medication. He was admitted on 29 September and discharged on 5 October 1999.

According to his discharge summary he was assessed as medically stable and ongoing geriatric involvement was not required. His mental state examination recorded no evidence of thought disorder, delusions, hallucinations or other psychotic phenomena and no suicidal or homicidal ideations at the time of discharge. His mood appeared anxious though he was subjectively depressed. He was tried

[2] Exhibit 1 Volume 1 Tab 12

on the antidepressant medication, Venlafaxine, and he was removed from other medications. He was to continue to be medicated whilst at home under the support and supervision of his general practitioner.

The deceased's GP, Dr Anderton, was supportive of him being managed at home although the deceased was recorded as being reluctant to accept home treatment in view of the fact he preferred a residential care option. He did not want to care for himself.

He was recorded as being apprehensive regarding his discharge.

It was as a result of his reluctance to receive home care on release from the MSC in October 1999 the deceased committed the offence for which he ultimately received a term of imprisonment expected to extend until his death.

The deceased's medical reports indicate he had been investigated for delusional disorder hypochondriasis, paranoid personality disorders, hypertension, hypolipediamia and peripheral vascular disease.

One of the deceased's delusional beliefs was he believed his wife, although they were separated, was having an extra-marital relationship with the GP who was responsible for his

care on release from hospital on the 5 October 1999. The deceased's GP had been caring for the family for 20 years and had agreed to care for the deceased at home when no residential accommodation could be found for him.

The deceased was very angry and blamed his doctor for the fact he could not obtain residential care or hospitalisation, and in conjunction with his belief the doctor was having a relationship with his wife premeditated a way to kill his GP.

At about midday on 8 October 1999 the deceased's GP went to visit him at his Forrestfield property at the deceased's request. As the doctor went to obtain his medical bag from the boot of his vehicle the deceased approached him with a loaded shotgun and fired it at him. The GP did not die immediately and whilst begging for his life, the deceased reloaded the firearm and shot the doctor a further three times in his shoulders, head and back. The GP died at the scene.

The deceased was arrested shortly afterwards and remanded in custody.

The deceased was committed for psychiatric assessment at Graylands Hospital under the *Mental Health Act 1996*. He remained at Graylands under 31 December 1999 when he

was remanded to Casuarina Prison as a remanded maximum security prisoner.

While in Graylands the deceased was recorded as having been diagnosed with suffering from a delusional disorder, hypochondriasis, paranoid personality disorder, hypertension, hyperlipedemia and peripheral vascular disease.

The deceased was convicted following a trial in May 2000. At his trial his evidence to the jury was he shot the GP because the doctor would not let him go back to hospital. He was sentenced on 15 May 2000 to strict security life imprisonment with a minimum of 20 years. It was considered likely he would die in custody.[3] His sentence start date was backdated to 8 October 1999 and he was due for release on 7 October 2019.

The offence, arrest and the following trial attracted considerable media interest at the time. He remained in custody in Casuarina Prison from 31 December 1999 until his death on 16 February 2012. His death was physically in RPH but he was still considered to be in custody as a sentenced prisoner. He was under the supervision of SERCO officers at the time.[4] He served a total of 4,430 days.

[3] Exhibit 1 Volume 1 Tab 14 15.5.2000 p254-262
[4] Exhibit 1 Volume 1 Tab 10 and 11

THE DECEASED'S INCARCERATION

The deceased had no record prior to the offence for which he was first incarcerated in 1999.

Following his arrest for the death of his doctor the deceased was admitted on a hospital order to Graylands Hospital as a patient under the *Mental Health Act 1996*. He was provided with a full psychiatric and medical assessment and was discharged on 31 December 1999 to the care and custody of Casuarina Prison, with follow up to be provided by the Prison Forensic Liaison Services if required.

The Graylands Hospital Discharge Summary records his prior history of contact with the RPH Psychiatric Unit and MSC where there had been an original diagnosis of mild depression, hypochondriasis and paranoid personality disorder. His compliance with treatment had been questionable.

Upon his receipt into prison on 31 December 1999 there was a standard Nursing Admission and Risk Assessment completed by the medical staff. They listed the deceased's multiple essential medications, the fact of his lower limb prosthesis and that he had suffered a stroke 8 years previously. He was considered to be a low risk of self harm and the reception At Risk Checklist recorded he was unsteady on his feet and recommended he be seen by the

Forensic Community Mental Health Team (FCMT) as soon as possible due to his age, the seriousness of his charge, and the fact his family were not supportive.

His later medical assessments indicated he was reluctant to communicate but was reviewed by the prison psychologist who noted no change to his status.

The deceased complained frequently with respect to right leg pain (amputation stump) and suffered a number of falls due to imbalance. He was referred to and attended external prosthetic, geriatric and ear, nose and throat specialist appointments for assessment and treatment.

The deceased did not attend CW Campbell Remand Centre due to his inability to mobilise steadily.

The deceased had been expecting a very short term of imprisonment as the result of his offence and was shaken when he was sentenced to a term of strict security life imprisonment. As a result he was assessed by the FCMT and placed under observation in a medical cell until he was assessed as being stable with no thoughts of self harm or suicidal ideation.

Throughout the rest of his incarceration he remained at Casuarina Prison and spent most of his time in the infirmary

due to his health. Early in his incarceration there was a concern with suicidal ideation, but this passed.

The prison medical file for the deceased indicates he received medical attention with respect to his multiple medical conditions. He continued with ongoing pain from his right leg stump and in July 2001 was investigated for a possible metastatic bone disease. This was inconclusive.

On 9 August 2001 the deceased was registered as Phase I terminally ill prisoner on TOMS in accordance with *Policy Directive 08 – Prisoners with a Terminal Illness.* A Phase I prisoner on the TOMS Terminally Ill Offenders Module indicates a high probability of death.

The deceased was recorded as appearing cognitively impaired and reported to be uncooperative, demanding and aggressive at times whilst in custody. He remained in a wheelchair when not mobilising with a walking stick. He was incontinent of faeces and urine and suffered ongoing phantom leg pain managed by the Shenton Park Pain Clinic.

The deceased was on a nursing care plan where his needs and care were regularly reviewed in an attempt to optimise the management of his multiple medical and psychological issues although he was frequently noncompliant with treatment and medication.

In August 2001 he was estimated as having a potential life expectancy of only 12 months. In January 2002 the deceased was removed from the Terminally Ill register when it appeared his latest health risk had been overcome.

Investigation of the deceased's continued pain with respect to his right amputation stump revealed he had methicillin resistant *Staphylococcus aureus* positive organisms and conventional antibiotics were not useful in healing his wound. Consequently he required surgical revision of his chronically infected amputation stump while in custody on two occasions in September and October 2002. The RPH Discharge Summary recorded the deceased appeared to be manipulating his wound.

By December 2002 his amputation stump had healed although the registrar noted the aneurysm in both his legs required ongoing surveillance and an ultrasound appointment was arranged for the following year.

The deceased was issued with a wheelchair in custody in March 2003 and received a new right leg prosthesis in April with a walking frame.

In May 2003 he began experiencing pain in his left foot and developed oedema and redness extending from his great

toe upwards. He was initially diagnosed with cellulitis of the left foot and then gout. He required a big toe amputation of his left big toe in 2006 following the diagnosis in the previous years of acute renal failure.

Due to his incontinence it was felt the amputation of his left big toe had been compromised and eventually he was diagnosed with sepsis and delirium secondary to wound infection. This eventually resulted in April 2006 with a left below knee amputation.

On his return to the infirmary after the second amputation the deceased fluctuated between settled, drowsy, angry, aggressive and confused and began refusing medications, food and fluids. This necessitated him being hospitalised frequently for dehydration. It was apparent his mental state was deteriorating secondary to sepsis from his chest and/or wound infection. He was hospitalised on occasions and it was only after his return to prison his condition improved and he continued with medical care in accordance with his care plan.

His chronic bilateral stump pain continued and in 2008 necessitated the trialling of various opioids for pain management. It was established the deceased was sensitive to narcotics and codeine based medication and

this caused considerable difficulty in treating his periods of infection, especially urinary tract infections.

The deceased continued to be a difficult prisoner with respect to his medical treatment and frequently refused to comply with initiatives aimed at improving his welfare. His increasing dementia by 2009 often meant his behaviour was difficult to manage.

Over the subsequent years his condition deteriorated further and became more severe. The deceased was escalated to a Phase II prisoner in 2010. This is a rating given where a prisoner's death is considered to be imminent. Despite this rating in 2010, by November 2011 the deceased was still in the Casuarina Infirmary.

On 24 November 2011, during a routine cell check, the deceased was found to be cyanosed, with low blood pressure, low oxygen saturation and an irregular pulse. He was immediately given oxygen and arrangements made to transfer him by ambulance to RPH where he was diagnosed with an exacerbation of cardiac failure and Type 2 respiratory failure and given a diuretic.

The RPH physicians recommended he start BiPAP which is a form of positive airway pressure used to treat respiratory failure however the deceased refused to accept BiPAP

during his admission and became aggressive towards staff resulting in him being discharged from RPH and returned to Casuarina Prison Infirmary.

In December 2011 the deceased was discussed with the cardiology registrar at RPH and a referral was made for him for a cardiology outpatient appointment to review his heart failure. On 20 December 2011 the deceased was reviewed by one of the prison doctors who noted he had been placed on the terminally ill list, presumably based on his diagnosis of heart failure and respiratory failure and his refusal of treatment a year earlier.

Around 9 January 2012 the deceased developed a cough and runny nose. On review by the prison doctor it was felt he had a chest infection and he was prescribed an antibiotic and ventolin.

The deceased's vital signs were monitored regularly and he remained reasonably stable until the 12 January 2012 when he was found to be clammy with a low oxygen saturation. He was transferred to RPH Emergency Department where he was treated with IV antibiotics. While in hospital on this occasion the deceased was extremely uncooperative, he removed his IV cannula and disconnected his catheter. RPH staff had little option to treat him and he was transferred

back to prison where he continued to be monitored regularly by the infirmary staff.

On 30 January 2012 the deceased's medical file shows he was noted to be more sleepy than usual, although he did not complain of any particular symptoms and his observations were normal. The following day he was found semi-conscious with low blood pressure and was transferred back to RPH where he was diagnosed with septic shock secondary to a urinary tract infection. His condition improved with the treatment and he was discharged back to prison on 6 February 2012.

The prison infirmary staff noticed his physical health was continuing to deteriorate and the nursing staff commented he appeared gaunt and tired. He had pressure areas on both buttocks which were treated.

The deceased continued to deteriorate and on 10 February 2012 he developed a fever, his blood pressure again dropped and his respiratory rate increased. He was readmitted to RPH and received a further course of IV antibiotics, he appeared to improve but developed a rectal bleed.

After discussion with his family it was decided to treat the deceased palliatively and he died on 16 February 2012 while under guard at RPH.

The deceased's early release under the Royal Prerogative of Mercy (RPOM) provisions was considered but not recommended due to the fact there was no-one in the community prepared to care for him and all his palliative care needs were being adequately managed by the Department of Corrective Services and RPH at the time.

POST MORTEM EXAMINATION

The post mortem examination of the deceased was carried out on 21 February 2012 by Dr D Moss of the PathWest Forensic Pathology Lab.

Dr Moss found evidence of a large haemorrhage within the colon but could not identify the source of the bleeding. There was an abscess adjacent to the deceased's large bowel and diverticular disease of the large bowel was noted.

There was severe hardening and narrowing of the blood vessels over the surface of the heart, (coronary artery atherosclerosis) and emphysematous changes noted in the lungs. Microscopic examination confirmed scarring of the heart consistent with the deceased's medical history,

although there was no definite evidence of established bronchopneumonia. The deceased had been on antibiotics for a considerable amount of time and this is not surprising.

Toxicology revealed the presence of appropriate drugs consistent with his medical treatment and neuropathology showed multiple old strokes and complicated atherosclerosis of the arteries to the brain.

It was thought the sepsis diagnosed in hospital was likely to be secondary to the pericolic abscess identified at post mortem, which is likely secondary to his diverticular disease. The cause of the gastrointestinal haemorrhage could not be identified however it is likely to have been secondary to the ongoing sepsis, diverticular disease and abscess formation.

As a result Dr Moss considered the deceased's death to be a combination of his sepsis and gastrointestinal haemorrhage and that the deceased's considerable co-morbid medical conditions were likely to have played a contributory role in his death.

Accordingly Dr Moss determined the deceased's cause of death was "*Sepsis associated with a pericolic abscess, complicated by terminal large intestinal haemorrhage*".[5]

[5] Exhibit 1 Volume 1 Tab 18

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was an 86 year old sentenced prisoner who had been incarcerated in Casuarina Prison, mostly in the infirmary, since May 2000.

He had a significant medical history prior to his imprisonment and this continued during the last 12 years of his life while in prison.

Although his discharge from the Mills Street Centre in October 1999 indicated he was not suffering thought disorder at that time it is clear the deceased was not entirely reasonable in his attitude to his GP. He blamed him for both his inability to remain in hospital and alleged an affair with his estranged wife. He quite deliberately put into action a plan to lure his GP to his home and then killed him.

There is no doubt the treatment the deceased received while in custody was significant in maintaining his life expectation despite his frequent lack of compliance and cooperation with those trying to treat him.

There was an expectation the deceased would die in custody following the seriousness of his offence and the late age at which he committed it. The offence itself arose out of some of the deceased's mental health issues for which he had been investigated while in the community.

Although the deceased was recorded as being terminally ill in 2001, he survived until 2010, without his condition being escalated to imminent death until 2010. Even then the deceased, with the care and treatment to which he was fairly resistant, remained in Casuarina Infirmary until the 10 February 2012 when he was transferred to RPH for the last time. He was treated palliatively and died on 16 February 2012 as a result of his combined medical conditions.

I find death arose by way of natural causes.

COMMENTS ON SUPERVISION, TREATMENT AND CARE OF THE DECEASED

I am satisfied on the whole of the evidence the deceased had multiple medical problems for which he was treated.

On his incarceration in Casuarina Prison from 31 December 1999 he was provided with ongoing medical assessment and nursing care mostly in the infirmary once his condition necessitated he be assisted with daily living requirements.

He was reviewed by external medical facilities for his specialist medical needs and provided with ongoing treatment and care on their advice. The deceased clearly preferred his care while in the infirmary to hospital as

evidenced by his general improvement and improved co-operation once returned to that facility.

I find the deceased's supervision, treatment and care whilst in the custody of Casuarina Prison was appropriate.

E F VICKER
ACTING STATE CORONER
20 December 2013